

Medical History Form

Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Sex: M F Ht: _____ Wt: _____ Dominant hand: Right Left

Family Doctor: _____ Who referred you to this office: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Reason for your visit today: _____

Symptoms: _____

Date /time of injury or symptom onset: _____

Is this injury or condition work related? Yes / No

How/where did the injury occur: _____

X-rays taken? When? _____ Results? _____

Please indicate which diagnostic tests you have had in evaluation of your problem.

X	EXAM	X	EXAM	X	EXAM	
	Plain X-ray		EMG/ NCV / SSEP		Bone Scan	Other:
	MRI		Discogram		Arthrogram	
	CT Scan		Myelogram		DEXA Scan	

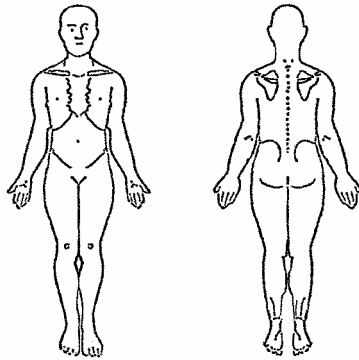
Please indicate which treatments you have had for your problem and indicate whether it was helpful or not.

X	Treatment	Helpful?		X	Treatment	Helpful?
	Electrical Stimulation				Massage	
	TENS				Pool exercises	
	Ultrasound				Home exercises	
	Hot packs				Manipulation	
	Cold packs				Acupuncture	
	Whirlpool				Injections	
	Other					

FOR DOCTORS USE ONLY

Using the symbols below, please draw in the location of your symptoms on the diagrams.

- XXX – Pain
- OOO - Numbness
- //// - Aching
- - Pins and Needles



Circle the number on the line below, indicating your usual level of pain.

(-0- means no pain, 10 means the worst pain in your life)

0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10
Least Worst

Activities of Daily Living: Please check the activities are currently limited due to this injury.

- Self Care such as: ___ bathing, ___ grooming, ___ dressing, ___ eating.
- Communication such as: ___ hearing, ___ speaking, ___ reading, ___ writing.
- Physical Activities such as: ___ standing, ___ sitting, ___ walking, ___ pushing, ___ pulling, ___ climbing.
- Sensory Function such as: ___ hearing, ___ seeing, ___ feeling, ___ tasting, ___ smelling.
- Hand Function such as: ___ grasping, ___ holding, ___ pinching.
- Travel: ___ riding, ___ driving.
- Sexual Function : ___ participating in desired sexual activity.
- Sleep: ___ having a restful sleep pattern.
- Social/Recreational activities: ___ Participating in activities, ___ sports, ___ hobbies.

What activity makes the symptoms/pain better? Please check what helps relieve your discomfort.

- | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|--|--|--|
| <table border="1" style="border-collapse: collapse;"> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> </table> <ul style="list-style-type: none"> General activity Bending Sitting Standing Walking | | | | | | | <table border="1" style="border-collapse: collapse;"> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> <tr><td style="height: 20px; width: 30px;"></td></tr> </table> <ul style="list-style-type: none"> Lying down Coughing Bowel movements Home remedies | | | | | |
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How long can you stand with no pain or minimal pain? _____

How far can you walk with no pain or minimal pain?

0-50 ft 50-200 ft 200-500 ft 500+ 1/2 + miles

Do you need support to walk? Yes No If Yes, what kind of support? _____

Do you wear a back brace neck brace? If Yes, how long? _____

Past Medical/Surgical History:

Medication allergies: _____

Current medications: _____

Medications you have tried in the past for this condition: _____

Any significant disease or medical condition, currently or in the past? _____

Previous surgeries: _____

Any significant disease or medical conditions in the family? (Father, Mother, siblings) _____

Substance use: Tobacco: Yes / No

Please indicate quantity per day: _____ Cigarettes _____ Cigars _____ Chewing tobacco (Snuff)

Alcohol: Yes / No

Please indicate quantity per day: _____ Beer _____ Wine _____ Liquor

Other: _____

Have you ever been treated for drug or alcohol addiction? Yes / No When? _____

Do you now or have you ever used illegal drugs? Yes / No What? _____

Are you Employed Retired
Day last worked: _____

Employer: _____
Job title: _____
Duties of your job: _____

Please Check any of the Following Symptoms that you have had in the past Year:

Constitutional:

- Chills
- Fever
- Loss of sleep
- Weight loss
- Weight gain

Gastrointestinal:

- Bowel changes
- Constipation
- Indigestion
- Rectal bleeding

Genitourinary:

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Skin:

- Bruise easily
- Changes in moles
- Rash

Eyes, Ears, Nose, Throat:

- Cataracts or glaucoma
- Blurred vision
- Difficulty swallowing

Musculoskeletal:

- Cramps
- Weakness
- Joint pain and/or swelling
- Morning stiffness

Cardiovascular:

- Chest pain
- High blood pressure
- Irregular heart beat
- Swelling of the ankles

Central Nervous System:

- Numbness/tingling hands
- Numbness/tingling feet
- Crying spells
- Seizures

Respiratory:

- Shortness of breath
- Asthma
- Bronchitis

Female History:

- Last menstrual period _____
- Hormone replacement
- Oral contraceptives

Male History:

- Prostate problems
- Prostate exam or PSA: _____

Western Reserve Spine and Pain Institute
WESTERN RESERVE PROFESSIONAL GROUP
307 West Main St. • Kent OH 44240
Ph. 330-677-3628 • Fax 330-677-3626

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Information to be Used or Disclosed

The information covered by this authorization includes:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person or organization

Name of person or organization

Persons to Whom Information May be Disclosed

Information described above may be disclosed to:

Name of person or organization

Name of person or organization

Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Western Reserve Spine and Pain Institute (Western Reserve Professional Group). You should contact the Privacy Office, Kelly Semancik to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Regulations.

Signature

Name of Patient (Print or type)

Signature of Patient

Date

Signature of Patient Representative

Relationship

Western Reserve Spine and Pain Institute
WESTERN RESERVE PROFESSIONAL GROUP
307 West Main St. • Kent OH 44240
Ph. 330-677-3628 • Fax 330-677-3626

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute, "Company", is required to maintain the privacy of your health information and to provide you with this Notice about our privacy practices, legal duties and your rights concerning your protected health information ("PHI"). If you have questions about any part of this Notice or if you want more information about the privacy practices at this Company, please contact:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute
307 West Main St., Kent OH 44240
Kelly Semancik, Privacy Officer

Effective date of this Notice: April 14, 2003

I. HOW THIS COMPANY MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION ("PHI").

This Company collects protected health information ("PHI") from you and stores it in one or more ways including, but not limited to, paper charts and files, electronic media, and computer storage. This is your medical record. The medical record is the property of this Company, but the PHI in the medical record belongs to you. This Company protects the privacy of your PHI. This Company is legally permitted to use or disclose your PHI for the following purposes:

TREATMENT. This company may use and disclose your PHI when you need a prescription, lab work, x-ray, or other health care service. In addition, we may use and disclose your PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose your PHI to your new physician regarding whether you are allergic to any medications. We may also disclose your PHI about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician to whom we are referring you to so that the other physician may treat you.

PAYMENT. This company may use and disclose your PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval for your health plan before we provide care or services. We may use and disclose your PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose your PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose your PHI to insurance companies providing you with additional coverage. We may disclose limited parts of your PHI to consumer reporting agencies relating to collection of payments owed to use.

This Company may also disclose your PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company or health plan. For example, we may allow a health insurance company to review your PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

HEALTH CARE OPERATIONS. This Company may use your PHI in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

YOUR AUTHORIZATION. In addition to this Company's use of your PHI for treatment, payment and health care operations, you may give us written authorization to use or disclose your PHI to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure of your PHI permitted while the authorization was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI except as set forth in this NOTICE.

DISCLOSURES TO YOU, YOUR FAMILY AND FRIENDS. This Company will disclose your PHI to you as described in the Patient Rights section of this NOTICE. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your health care, but only if you agree that we may do so.

NOTIFICATION AND COMMUNICATION WITH FAMILY. This Company may disclose your PHI to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family or others.

REQUIRED BY LAW. This Company may use and disclose your PHI information when required to do so by Law.

PUBLIC HEALTH. This Company may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration, problems with products and reactions to medications; and reporting disease or infection exposure.

HEALTH OVERSIGHT ACTIVITIES. This Company may disclose your health information to health agencies for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

DECEASED PERSON INFORMATION. This Company may disclose your health information to coroners, medical examiner and funeral directors.

ORGAN DONATION. This Company may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

PUBLIC SAFETY. This Company may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

WORKERS' COMPENSATION. This Company may disclose your health information as necessary to comply with Workers' Compensation laws.

APPOINTMENT REMINDERS, TEST RESULTS AND TREATMENT INFORMATION. This Company may contact you to provide appointment reminders, test results or to give your information about other treatments or health-related services that may be of interest to you. This may include voice mail messages, postcards, letters, e-mail and other forms of communications.

II. WHEN THIS COMPANY MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION. Except as described in this Notice of Privacy Practices, this Company will not use or disclose your health information without your written authorization. If you do authorize this Company to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. YOUR HEALTH INFORMATION RIGHTS.

1. You have the right to request restrictions on certain uses and disclosures of your health information. This Company is not required to agree to the restriction that you request.
2. You have the right to receive your health information through reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your health information. This Company may impose a charge for copying expenses.
4. You have a right to request that this Company amend your health information that is incorrect or incomplete. This Company is not required to change your health information and will provide you with information about Company denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by this Company, except that this Company does not have to account for the disclosures for treatment, payment, health care operations, information provided to you, or certain government functions described above.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute
307 West Main St., Kent OH 44240
Kelly Semancik, Privacy Officer

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES. This Company reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, this Company is required by law to comply with this Notice.

V. COMPLAINTS. Complaints about this Notice of Privacy Practices or how this Company handles your health information should be directed to:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute
307 West Main St., Kent OH 44240
Kelly Semancik, Privacy Officer

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Ave, S.W.
Room 509F HHH Bldg.
Washington DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found on-line at <http://www.hhs.gov/ocr/regmail.html>.

If you are not satisfied with this Company's response, you may file a complaint with:

Regional V, Office for Civil Rights	Ph: 312-886-2359
U.S. Department of Health and Human Services	Fax: 312-886-1807
233 N. Michigan Ave., Suite 240	TDD: 312-353-5693
Chicago IL 60601	

Alternatively, you may e-mail a complaint to: OCRComplain@hhs.gov . For further information, contact:

Office for Civil Rights	Ph: 202-205-8725
Department of Health and Human Services	
Mail Stop Room 506F	
Hubert H. Humphrey Building	
200 Independence Ave, SW	
Washington DC 20201	

COMPANY WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute
307 West Main St., Kent OH 44240
Kelly Semancik, Privacy officer

I hereby acknowledge that I received or was provided the opportunity to receive a copy of Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute’s Notice of Privacy Practices.

PATIENT INFORMATION:

Print Name: _____

Signature: _____

Date: _____

Telephone: _____

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE):

Print Name: _____

Nature of Relationship: _____
(i.e. - Parent, Guardian, Beneficiary or Personal Representative of Deceased Patient, etc.)

Signature: _____

Date: _____

For Office Use Only:

- Signed form received.
- Acknowledgment Not Obtained.
- Patient Refused.
- Emergency -
- Other - _____

Print Staff Member’s Name: _____

Staff Member’s Signature: _____

Date: _____